

**AHNCI COLON AND RECTAL TUMOR BOARD**

Friday, January 24, 2020

7:00am-8:00am

Pugh Classroom, 2nd floor, AHNCI

Zoom Meeting: <https://zoom.us/j/966171364>

Dial US: 646-558-8656

Meeting ID: 966171364

**Cases to be discussed**

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| **Case**  | **De-identified patient** | **Reason** | **Presenter** |
| 1 | LP/ MRN: 5932067DOB: 2/19/48 | 71 y/o female with recently diagnosed locally advanced rectal cancer with rectovaginal fistula.  The patient presented emergently with obstructive symptoms rectal bleeding pelvic pain, was noted to have a large pelvic mass, biopsy-proven adenocarcinoma of the rectum with the involvement of the vagina, perforation into the left ischiorectal space, large bulky tumor within the pelvis.  Cachectic over 100 lb. weight loss.  She required proximal fecal diversion with loop sigmoid colostomy performed in December by Dr. Recio for obstructive symptoms.  Being treated at St Vincent’s Cancer Institute. Review scans and treatment options. | SN |
| 2 | EW/ MRN: 5957151DOB: 04/25/53 | 66 y/o female with metastatic microsatellite unstable rectal cancer with pulmonary metastasis.  Follow-up CT imaging in January 2020 demonstrates enlargement of a right upper lung metastasis adjacent to the mediastinum.  Review imaging studies and tumor measurements.  Discuss treatment options. | GF |
| 3 | LG/ MRN: 11824459DOB: 6/14/50 | 69 y/o female being seen for newly diagnosed rectal mass. She underwent a colonoscopy by Dr. Krysia Zancosky for a positive Cologuard test and was found to have a fungating and infiltrative partially obstructing large mass found in the recto-sigmoid colon. It was biopsied and tattooed and came back as invasive adenocarcinoma. Review scans. | JM |
| 4 | DB/ MRN: 40251DOB: 12/18/59 | 60 y/o male who presented to the ED for rectal bleeding on 10/4/19.  A colonoscopy done on 10/11/19 revealed a rectal mass that was biopsied and confirmed an invasive moderately differentiate adenocarcinoma.   CT scan of the abdomen and pelvis (10/4/19) revealed a semi circumferential wall thickening of the mid to upper rectum suspicious for rectal cancer.  Bibasilar pulmonary nodules concerning for metastases were noted also.   Enlarged inter aortocaval lymph node (1.8 x 1.7 cm), indeterminate but could also represent metastasis.  MRI on 1/22/19 showed a T3N1M1 mid rectal cancer with extension into the mesorectal fat.  His case was presented at tumor conference on 10/25/19 and the consensus was that he would need 3 months of FOLFOX followed by repeat imaging.  Started FOLFOX on 11/5/19 and just received cycle # 6 on 1/14/20 with plans for 2 more cycles. Recent CT scan on 1/8/20 shows partial response and CEA has dropped from 23 to 3.1. Review scans and discuss treatment options. | DM |
| 5 | ND/ MRN: 11801564DOB: 1/8/46 | 73 y/o male with rectal cancer. He underwent a colonoscopy on 11/26/19 by Dr. Fadden and was found to have an ulcerated partially obstructing large mass found in the mid rectum and in the distal rectum. The mass was circumferential and measured 3 cm in length and was biopsied and came back as invasive moderately differentiated adenocarcinoma. CEA was 12.1. CT A/P was done on 11/26/19 and showed findings highly suspicious for a rectal mass originating approximately 5.5 cm proximal to the anus, no discrete evidence of lymphadenopathy or infiltrative changes. No definitive evidence of local or distant metastatic disease, fatty infiltration of the liver is noted. A CT chest showed spiculated mass in the inferior aspect of the right middle lobe measuring up to 1.3 cm (recommended biopsy),and a pleural based thickening in the posterior right lung base.  MRI done 12/17/19 revealed a T3cN2 MRF positive mid high circumferential tumor which narrows the rectal lumen.  Discussed at tumor conference on 12/20/19 with the consensus being palliative short course radiation followed by Hartmans vs APR.  Patient was scheduled to receive short course radiation in hospital from 1/20-1/24/20 with surgery following on 1/30/20.  He was admitted on 1/19/20 and received one radiation treatment, then signed himself out AMA on 1/21/20. | JM |
| 6 | LM/ MRN: 11812119DOB: 9/3/37 | 82 y/o female who was referred after a colonoscopy was performed on 12/18/19 showing an endoscopically unresectable cecal mass x 2, endoscopically unresectable proximal ascending colon mass x 1, and a large left lateral mid-rectal mass x 1 at 7 centimeters from the anorectal junction. Pathology revealed the rectal mass to be a tubulovillous adenoma with focal high grade dysplasia. All other masses were benign. CT CAP and MRI done on 1/10/20 with MRI reporting no convincing evidence of a rectal mass. Questionable polyp versus retained stool in mid rectum. If treated as a rectal mass, this would be a T1 or T2 N0 CRM negative lesion. Flex sig done on 1/22/20 by Dr Fortunato. Review scans and discuss treatment options. | RF |
| 7 | GL/ MRN: 780224DOB: 11/1/41 | 78 y/o male with stage IV rectal cancer (T3cN0M1 with CRM involvement and metastatic to inguinal node). He was originally discussed at the Multidisciplinary Colorectal Cancer Conference 8/9/19 and the plan was to enroll him in the FR2 trial do FOLFOX followed by IMRT chemoradiotherapy and restage and potentially proceed with resection of the primary tumor. He began chemotherapy on 8/27/19. Had 3 cycles, with some delays. Flex sig 10/21/19 by Dr. McCormick revealed the tumor in the upper rectum was now not able to be traversed. The tumor was friable and there was quite a large luminal component. Consistent with a poor response to therapy and progression despite therapy. He was again discussed at the Multidisciplinary Colorectal Cancer Conference 10/25/19 and the group recommended proceeding with chemoradiotherapy next followed by surgery (resection +/- end colostomy). He was not eligible for the FR2 trial due to chronic osteomyelitis requiring Bactrim for management. PET/CT 11/5/19 that showed hypermetabolic mid rectal thickening, hypermetabolic right common iliac and right external iliac lymph nodes consistent with metastatic disease, mildly hypermetabolic, and borderline enlarged right inguinal and femoral lymph nodes may be inflammatory or metastatic; hypodense, mildly hypermetabolic left adrenal nodule. Completed chemo/radiation 12/23/19. Flex sig done by Dr. McCormick on 1/20/20 showed a mass in the mid to upper rectum that demonstrated good response to therapy. CT C/A/P done 1/21/2020. Review scan | JM |
| 8 | JB/ MRN: 794316DOB: 11/20/63 | 56 y/o male initially diagnosed with rectal cancer 6/19 after a colonoscopic evaluation secondary for rectal bleeding. Biopsies were confirmatory to be moderately differentiated adenocarcinoma of the rectum.   Based on the initial MRI in the summer of 2019 patient's stage is T3 N0 Mx and a systemic workup at that time revealed no evidence of metastatic disease.  Patient is suffering from alcoholism, he has had DTs in the past, and he was told he has cirrhosis, said ascites in the past.  Evaluation by Dr. Kondil revealed no prohibitive liver dysfunction. Case presented at tumor conference on 9/27/19 with the consensus being to proceed with a short course radiation therapy, however due to patient’s non-compliance it wasn’t completed until 12/14 at Allegheny General Hospital as an inpatient admission. Robotic abdominal perineal resection with end colostomy with extensive LOA done at Allegheny General Hospital 1/2/20. NAPRC path review. | SN |
| 9 | GS/ MRN: 132528 | 74-year-old male with extensive cardiac history with biopsy confirmed poorly differentiated adenocarcinoma of the sigmoid colon. Patient underwent colonoscopy by Dr. Kulkarni on 10/18/2019 for GI bleed during an admission for bacteremia and bioprosthetic valve endocarditis. Colonoscopy showed a 6 cm sigmoid polyp that was resected piecemeal with biopsy showing moderately-poorly differentiated adenocarcinoma arising in a tubulovillous adenoma with high grade dysplasia, carcinoma present at resection margins, and no lymphovascular or perineural invasion. Previous colonoscopy in 12/2018 showed multiple tubular adenomas that were not removed due to GIB on DAPT, and follow-up colonoscopy with polypectomy was postponed due to subsequent cardiac illnesses. CT chest abdomen pelvis on 10/23/2019 showed no evidence of metastatic disease, an unchanged 7 mm left upper lobe pulmonary nodule, and fluid third spacing. Follow-up with colorectal surgery and medical oncology was postponed due to another admission in December prompted by volume overload, worsening acute renal failure in the setting of RV dysfunction. CEA pending. Review PET/CT imaging and discuss treatment planning. | RF |
| 10 | JC/ MRN: 11266158DOB: 3/20/52 | 67 y/o male diagnosed with metastatic ascending colon cancer to the liver with indeterminate pulmonary nodules diagnosed in June 2018.  Had multiple cycles of chemotherapy.  CT 7/15/19 showed significant response, no evidence of the liver lesions and stable pulmonary nodules.  Colorectal conference on 8/2/19 recommended proceeding with resection of primary tumor.  W/U for surgery found patient needed a CABG. Done on 9/9/19.Right colectomy done on 12/11/19 by Dr. McCormick.  Pathology revealed T3N1b moderately differentiated adenocarcinoma with perineural invasion, 2/25 lymph nodes positive, and one tumor deposit identified. CT C/A/P done 1/16/20 showed increase in size of multiple nodules concerning for metastatic disease. Two indeterminate low-density areas in the liver.Asking for scan review. | NA |
| 11 | TP/ MRN: 174600DOB: 10/12/59 | 60 y/o male presenting originally to discuss colonoscopy results as part of his workup for ostomy takedown. The patient had his loop ileostomy created on 9/25/2019 during laparoscopic converted to open low anterior resection for diverticulitis of the large intestine with abscess formation. Colonoscopy on 12/4/2019 showed a healthy appearing anastomosis and intact staple line, and a frond-like/villous and polypoid non-obstructing, non-bleeding, large mass in the mid rectum measuring 3 cm in length, 2 mm diameter. Biopsy showed tubulovillous adenoma. On 12/11/19 a rectal US was performed that identified the mass as T0N0.   MRI pelvis done on 12/18/19 showed T1 versus T2N0 CRM negative mid rectal cancer.  He was presented at tumor conference on 12/20/19 where the group recommended a full thickness excision which was done on 1/15/20 and pathology again showed tubulovillous adenoma. Review pathology and scans. | RF |

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Objectives

Upon completion of this activity, participants will have a better understanding of decision-making for complex colon and rectal problems and be armed with clinical pathways to improve care.

Accreditation:

Allegheny General Hospital is accredited by the Accreditation Council for Continuing Medical Education to provide continuing education for physicians. Allegheny General Hospital designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure:

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Moderators: Alexander Kirichenko, MD /Dulabh Monga, MD /James McCormick, DO/Richard Fortunato, MD